Dialogus

"A Free E-mail Newsletter – Furthering the Dialogue to Better Serve Survivors of Torture"

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Dialogus provides a forum for members of the torture treatment centers in the U.S. who serve survivors of torture to participate in a dialogue about innovative approaches in their work with survivors as well as share resource information, news, and solutions to challenges we face. We hope that you will enjoy being part of this forum and community. However, if you wish to unsubscribe to Dialogus in the body of the text, just type: Unsubscribe (your e-mail address).

In This Issue You Will Find:

Article: "Understanding Terror-induced Trauma" by Yael Fischman, Ph.D.

Article: "Dance Movement Therapy with a Child Survivor: A Case Study" by Amber Gray, MPH, MA, DTR, BENCC

Call for Submissions: How to Contribute to Dialogus
Resources: Web Sites of Treatment Centers

Article:
"Understanding Terror-induced Trauma"

by Yael Fischman, Ph.D.

** Acknowledgement: I thank Jaime Ross, Ed.D, for his critical review of this article.

Introduction

The terrorist events of September 11 have generated increased awareness on the subject of human- induced trauma. Inasmuch as natural disasters can be extremely distressing and anxiety provoking, the intentionality involved in human- induced disasters tends to cause deeper psychological injury.

These recent terrorist episodes have evoked reactions such as shock, disbelief, disorientation, fear, concerns about safety, anger and grief. After the initial shock reaction, we are hearing of symptoms such as mood swings, irritability, hypervigilance, fatigue, trouble concentrating, and difficulty sleeping.

In addition to providing emotional support, mental health providers need to let people know that these are normal reactions in these circumstances. Also, some practitioners may want to the address somatic symptoms, which have included increased heart rate, fast respiration, tensing of the stomach muscles, or feeling cold. The activation of these symptoms and eventual return to homeostasis result from the action of the hypothalamus-pituitary-peripheral-gland links. Situations perceived as emergencies drive the sympathetic nervous system to release its chemical messengers.

Somatic symptoms thus develop when the limbic system 'reacts' to the perception of threat. The hypothalamus signals the sympathetic nervous system, which in turn stimulates the adrenal glands to release epinephrine and norepinephrine to mobilize the body for 'fight or flight'. The parasympathetic nervous system works in opposition to the sympathetic nervous system. When the traumatic incident is over, the parasympathetic nervous system stops the alarm reaction by turning off the production of epinephrine and norepinephrine and allowing the body to return to its pre -trauma state.

Retraumatization

People who have experienced a traumatic event related to war, torture, or other situations in which their safety has been compromised, are vulnerable to re-experiencing such traumatic events when they witness (directly or through the media) a situation such as the recent tragedy in New York.

Exposure to an unsafe environment, an experience of intense helplessness, or the inability to control profoundly painful situations, may lead traumatized persons to re-experience prior traumatic events. The activation of earlier traumatic memories may generate heightened emotional reactions to stimuli reminiscent of their previous trauma.

Old memories related to war, torture, rape or other painful events might reappear, usually in the form of flashbacks. Posttraumatic flashbacks are a perceptual re-experience of a specific traumatic event. For example, the sight of an airplane crashing into a building in New York City may elicit in war refugees a vivid flashback of a similar event at their country of origin. Sights, sounds, or smells associated with previous traumatic experiences may all trigger traumatic flashbacks.

Traumas may also be re-experienced in situations that are different from the initial trauma. They may reappear in the form of nightmares or flashbacks. According to Briere (in press) these intrusive experiences include both the memory of the traumatic event and the negative affective responses which have been classically conditioned to such memory.

The activation of traumatic memories may cause diverse symptoms such as feeling paralyzed, cold, hypervigilant or with irregular or fast heart beating; also anger, shock, frustration, fear or sadness. Special attention might be directed at certain sounds, movements, smells, or words that bring memories of past unsafe or menacing events. Some people will experience numbness, emotional constriction, or a need for distancing or social isolation.

In addition to clear symptoms of retraumatization, refugees recently arrived from countries torn by war are expressing serious concern about their safety. We are

hearing questions such as "if this is not a safe place, then what is?" Besides providing emotional support, it is necessary to gradually tap into their inner resources. This process will assist them in the development of new paradigms of safety in an apparently menacing world.

The recent acts of terrorism have not only affected those who waited for years to come to a country that they saw as their only safe haven from war and terror. Some health centers have also seen an increase in request for services by survivors of state terror in their own countries decades ago. For example in a recent article published in the Los Angeles Times , Ariel Dorfman speaks on behalf of his compatriots:

> "I have been through this before. During the past 28 years, September 11 has been a date of mourning, for me and millions of others, since that day in 1973 when Chile lost its democracy in a military coup, that day when death irrevocably entered our lives and changed us forever."

Hence, Chilean immigrants requesting services at this time are possibly dealing with the impact of retraumatization. Many are flooded by recollections of another Tuesday September 11, when the day started with "terror descending from the sky" to destroy the official presidential residence. In a similar vein, many Asian survivors of war trauma who found refuge in this country decades ago, are now displaying trauma symptoms and expressing severe concerns about their safety and their ability to protect their families. In this regard it might be helpful to keep in mind that for most refugees, traumatization is a cumulative ongoing process. It includes the initial trauma of arrest, torture or war, and continues with a dangerous journey to a place of exile. It also requires dealing with losses of loved ones, home, community and legal status, as well as adaptation to life in exile.

Hate Crimes and Retraumatization

As a result of the recent events, there have been acts of physical brutality, and displays of racial hate against people of Arabic descent in several places across the country. These attacks have deeply affected individuals of Arabic origin who were born and raised as American citizens, and have contributed to retraumatize a large number of Muslim refugees who are new to this country. As days have gone by, Muslim clerics are reporting that for every act of hatred, they are now

seeing ten acts of good will. This sentiment was echoed in a recent meeting of diverse religious leaders hosted by the Simon Wiesenthal Center in Los Angeles. Inasmuch as members of traumatized ethnic minorities must hear, unequivocally, that we strongly oppose all hate crimes, it may be helpful for them to understand that such aggressive reaction has stemmed from fear-induced rage. Terrorism elicits very strong emotions, leads many to feel that the world has become an unsafe and unpredictable place, and irrationally believe that attacking the dangerous "others" will increase their security.

The Healing Process

The complex reality of people traumatized by the intentionality of human-induced disasters presents a special challenge to caregivers. The processing and resolution of trauma symptoms in a context of safety and support requires an understanding of the impact of trauma as a psycho-physical and a psycho-spiritual experience. (For references related to the healing process, please refer to Rotschild, 2000; Ross & Gonsalvez, 1993; Herman, 1992; van der Kolk, 1987; Bettelheim, 1980; Krystal, 1968) It is important to be mindful of the meaning that each individual ascribes to the trauma, and of the social, political and ethical implications that arise as aftereffects of human-induced trauma. Adequate treatment should address all these elements as different, albeit interactive domains of the patient's experience. (References for this subject include work by Fischman, 1998; Brom and Witzum, 1995, Kinzie and Boehnlein, 1993; Eth, 1992; Pope and Garcia-Peltoniemi, 1991.)

The planned nature of disasters such as those of September 11, 2001 tend to shatter people's belief in personal invulnerability and in the world as predictable. To reestablish a belief in a predictable and meaningful world and a reconnection with purpose, it may be necessary to explore different existential concerns. Since there are no universal answers to such issues, each clinician will access the spiritual, ethical and moral resources that are congruent with his or her belief system, and translate those into therapeutic interventions responsive to patients' needs.

In the aftermath of this tragedy, we hear about people seeking revenge at any cost. However, others are trying to reestablish a sense of meaning by channeling their emotions into positive action. Some are trying to develop new paradigms for life and safety, which tend to be more spiritually oriented than their previous ones.

Others are gravitating towards religion. We are hearing more about prevalence of spirit over matter, of good over evil.

The Jewish Day of Atonement, Yom Kippur, happened to fall very shortly after the events in New York. As has been the case with other religious leaders, rabbis focused on the need to unite in prayer. The following excerpt of a sermon by Rabbi Simon Jacobson of Meaningful Life Center (www.meaningfullife.com) seems to summarize much of the current sentiment:

> "Yom Kippur is the holiest day of the year because it is the birthday of the single most important ingredient in life: HOPE . . . that there is healing after loss, that there is hope after destruction. That even after great loss we can rebuild in ways that are greater and stronger than ever before . . . We must channel our potent reactions into a force for good. Especially after we have witnessed the vehement passion of madmen, our commitment to goodness and love has to be with at least as much passion as the horror waged against us. For every force of evil there is an equal and even greater force of good. When we fear evil conspiracies - awful people gathering to perpetrate terrible acts - we must congregate together with even more passion to recommit to our battle for justice and virtue . . . Let us resolve now to join together to create an unprecedented amount of light, more powerful than any opposing force, a unity that manifests the greatest blessing of all: Shalom, peace and wholesomeness for all people. We are on the verge of a spiritual revolution - a transformation from within."

The Wounded Healers: Vicarious Traumatization

The search for meaning is also relevant for caregivers. Many are feeling overburdened by the amount of pain that patients are bringing into treatment. Figley (1995) writes about compassion fatigue. Other terms used to describe the impact of the trauma on caregivers include "secondary wounding," "contact victimization," "secondary traumatic stress," and "traumatic countertransference."

McCann and Pearlman, who in 1990 introduced the concept of vicarious traumatization, state that persons who work with victims may experience disruptive and painful psychological effects and go through a transformation that parallels the experience of the victim. This entails changes in their identities, worldview, self-capacities, ego resources, cognitive schemata and psychological

needs. Herman (1992) affirms that trauma is contagious and that the clinician may experience, to a lesser extent, the same terror, rage and despair as the patient.

The study of human-induced disasters corroborates that those in secondary contact with the victim's suffering are themselves vulnerable to develop traumatic countertransference. Therapists working with individuals traumatized by violent political repression may undergo intense emotional responses, ranging from denial to overidentification. (Fischman, 1991).

Clinicians have an ethical responsibility to deal with their own secondary traumatic stress, otherwise they either minimize their ability to heal, or may even harm the therapeutic process care. McCann and Pearlman (1990) focus their attention on therapist's self care and emphasize subjects such as balance, self acceptance, and connection.

The terror is impacting caregivers. We know by now that crisis workers are at risk of developing both primary traumatic stress due to their direct exposure to traumatizing events, and secondary traumatic stress, from aiding traumatized persons. Consequences may include ill health, substance abuse, and relationship difficulties. According to T. Torres (personal communication, October 9, 2001) a number of rescue workers at the site of the Oklahoma City bombing showed significant psychological aftereffects such as disruptions in interpersonal relationships, episodes of substance abuse and other serious psychiatric symptoms. It will be useful to obtain information on the impact of that event on clinicians, and assess their level of vicarious traumatization.

Clinicians are being exposed to the same traumatogenic environment as their patients. Some are experiencing the aftershock of the September events with the same intensity as their patients. Others are themselves refugees and are experiencing symptoms of retraumatization. There might be those who have suffered a more direct impact if people close to them died in the New York attacks.

Up to date the subject of therapy in a traumatizing environment has been more pertinent in countries where therapists themselves have been exposed to direct or indirect repression. For example, Elizabeth Lira (1995) discusses her experience treating victims of political repression in Chile. Therapists there felt compelled to become deeply involved. The graveness of the situation and their level of commitment led them to work long hours. They did not take care of their health or of their own personal problems.

These clinicians were affected by the patients' sufferings and by political threats, but were not aware of their own individual reactions. The impact of this threat was not sufficiently registered to elicit adequate psychological support for them. The demand for assistance was too immediate to allow a proper consideration of the impact on therapists. Lira states that traditional distancing resources are hindered when therapist and patient share the same historical period and the existing threats make them equally vulnerable.

Other clinicians working under conditions of war or state terrorism have made reference to feelings of loneliness, abandonment, isolation and marginality. Interestingly, therapists treating exiled survivors of torture in countries of refuge have echoed similar feelings. These feelings may well be inherent to this type of work. They lend themselves to diverse interpretations and should be explored further in a separate study.

This may be a time for clinicians to increase opportunities for self care and peer support. Some may also wish to stay connected to a source of meaning or to explore new paradigms to understand and deal with human pain.

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"Dance Movement Therapy with a Child Survivor: A Case Study"

by Amber Gray, MPH, MA, DTR, BENCC

Haiti is an island of contrasts and extremes: rich cultural traditions and oppressive poverty, polluted filth and beautiful landscapes, fine artistry and unbearable suffering. The history of Haiti is one of bloodshed, oppression, and an ongoing struggle for liberation that still continues. One of the most tragic outcomes of this state of affairs is the suffering experienced by children.

The case study presented here describes my work with a former street child — one of an estimated 300,000 street children in Port Au Prince alone -- who is also a survivor of torture. He was found on the streets several years ago by members of a program called "Wings of Hope" (WOH). WOH run a group home for abandoned children who are also emotionally and physically challenged.

The work described in this case study derives from the fields of somatic psychology and dance movement therapy (DMT). Somatic psychology posits that mind and body are not separate, but are unified, and dance movement therapy is based on the belief that emotional and psychological well-being is directly related to an individual's movement repertoire because movement reflects our inner states. The theory supporting the interventions presented in this case study were described in the article called, "Healing the Relational Wounds of Torture Through Dance Movement Therapy" in the May 2001 edition of Dialogus (Vol. 5, No. 1).

Case Study:

George is a 17-year-old boy who is severely undersized from malnutrition and abuse. He was found on the streets of Port Au Prince, Haiti in 1996, tied and bound at his wrists and ankles, where he stills bear scars from the tight ropes. He was repeatedly tortured and beaten for many years.

I worked with George at a home for mentally and physically challenged children in Haiti. When I first met him, he would not participate in group activities. His body posture was fixated in the position he was found and tortured in. He was tightly bound in a twisted fetal position on the floor, and always faced the wall with his head turned to the right. He never interacted with the environment or other people. He was mute and constantly gazed downward. He sat for hours and

days in this state, only eating or preparing for bed when approached.

George responded to only one invitation; if he were approached from his left side he would grab the outreached hand and push hard into the person approaching him. He would then push his companion around the periphery of the home, up and down all the stairs, and through every room, never crossing through the center space. He always remained peripheral, and he always pushed with force. When he was approached from the right side, he turned away, evidence of a boundary rupture on this side. It bears noting that George's single-armed pushing pattern (homologous push) was a very early developmental movement that appeared to be truncated at a fixated, frozen shoulder.

Initially, I allowed George to push me to get a sense of his movement patterns. One day I decided to push back, and did so with resistance. He immediately spun his body to the right and into me, completely merging his body with mine and burying his head into my abdomen. This was evidence of boundary rupture, and after we repeated this interaction several times, I learned that George could not negotiate anything other than an isolated or a fused boundary. He either pushed away and isolated, or enmeshed and fused. The right side appeared to be the site of the strongest rupture.

Following this interaction I encouraged George to differentiate from me by allowing him to push me around the space in his usual way. In our next session, I tried something different: I met his push with a different intention. Rather than push back in resistance, I received his push. I realized my resistant push may have too directly mirrored his push, re-activating the relational wound. His merging response may also have indicated forced fusion with the perpetrator.

Initially, this new way of relating appeared to confuse him. He froze, then began to turn left to right and right to left, as if he were a dancer twirling in my arms. He attempted to wrap himself around me again, spinning to the right. I was prepared. I gently steered him to the left in a non-threatening, compassionate manner, and turned him to face away from me. I rested my hands softly on his shoulders in a gesture of support. He stood there for awhile, as if contemplating this, then tried to wrap himself into me again. When I gently encouraged him to keep a healthy distance from my body, he tried to push me around the space. I allowed him to do this briefly to regain control, but after we had walked the entire periphery I began to meet his push again, steering him gently to center. At this point he followed me, and as we moved through the center of the home a tiny smile appeared on his face.

In subsequent sessions, I introduced a tuning board as a transitional object and physical boundary between us. As we did our "push and twirl" dance, I wedged the board between us. The tuning board, developed by Darrell Sanchez, is a pliable, circular object, brightly colored and usually pleasing to children. It is used to restore fluidity in a fixated, traumatized body. Transitional objects support a safe holding environment. He seemed to enjoy the board as it became more familiar.

I carried it with us on our walks, and when we returned we sat against the wall with it between us, always on his left side. He began to smile more. The fixation in his upper body was relaxing and a stronger spinal push was evident. Two things changed notably in his posture: he was extending his legs more in front of him, and while he still faced right, he did not face directly to the wall. His posture and movements appeared more relational.

At this point, I began to supplement our walks with range of movement exercises to gently encourage George to bridge more with his environment. As we walked, I raised my arm up, or squatted low, or opened my arms wide, inviting him to join me. As he became more comfortable with these movements, he begin to increase eye contact with an occasional peek at me. He began to smile more, evidence of increasing emotional expression.

As George grew more comfortably relational with me, we began to play ball. Initially, he would catch it if I threw it, but not return it. Eventually, he began to roll it back to me with a strong homologous push, a developmental move that precedes reaching. I created the ball game to introduce another transitional object, and to encourage George to face me more directly. Each time he looked at me, I said his name softly. I was beginning to acknowledge that I saw him.

Continued attempts to involve George in group activities were initially unsuccessful. On one of my last days, however, we began with our usual dance, which by now was a familiar greeting. George then took my hand and lead me to the wall, where we sat down with our backs against the wall. He placed the tuning board between us and extended his legs fully out in front of him with a homolateral reach, a yet more advanced and relational developmental movement. Several of the staff noticed this and expressed surprise. They had never seen him do this. He continued to sit facing into the room, and when other children began to gather around and play with balls and balloons, he remained. I initiated our ball game, and shortly another child joined us. The three of us played ball. The director of

the center commented that he had not seen George interact like this in his two years there.

George's kinesphere had expanded so that he bridged more with his environment, which was beginning to include other people. His timid eye contact indicated an increased comfort level with being seen, and his shy smiles were a sign of increasing affect. He was pushing with less fixation, and had begun to reach out in relationship. He was less protective of his right side, and was beginning to allow me to approach him from there, as long as he could see me. His ruptured boundary was healing, and he was learning to orient himself towards others more relationally. When it came time for me to return to the United States, I trained all the staff in the use of the boards and balls so that George's work could continue.

Discussion:

This is a particularly interesting case of DMT because our work was entirely non-verbal. We did not speak one another's language, and while George did not speak at all, he understood Haitian Creole. Our communication consisted entirely of movement.

My initial evaluation of George indicated a child with severe developmental trauma caused by torture. His virtual isolation in a tiny kinesphere and his inability to oscillate in and out of relationship made me suspect that he had not known healthy boundaries in relationship since he was an infant, if ever. These relational dynamics shifted significantly in our time together.

While my first instinct to push back may have challenged George, it provided me with useful assessment information. George had most likely internalized his early experience of torture in a body frozen and fixated, defensively and fearfully. On the rare occasions that he moved, he did so only by keeping a safe distance from his companion. His life was literally peripheral and isolated.

As our movement dialogues continued and he began to expand his individual movement range, his interaction with the environment and other people eventually increased. His increased use of developmental movements such as homologous pushes and homolateral reaches, early neurological actions that a healthy child moves through as s/he attunes to and explores his/her environment, facilitated this relational shift. I believe his increased use of these movements was restoring his developmental integrity as he reconnected with the primary movements that constitute healthy development. This could indicate early

disruption to his developmental process and to his ability to sequence experience normally. As George explored more of his environment, he showed increased affect as evidenced by his slight smiles and gradual attempts at eye contact. The process of gradually being met and seen was a healing one for him. Ultimately, George was able to maintain his presence in a group of very active children, and to look at me almost directly and smile, expressing perhaps some satisfaction at being in relationship.

Conclusions and Recommendations:

It has been said that it is through dance that the history of a people is enacted. If this is true, it can also be said that the history of an individual is enacted through the body. Dance/Movement therapy honors the powerful connection that the human body has to life experience. Because it is the body that suffers in torture, it is also the body that heals and rehabilitates. Working with, and through, the experience of the body and its expressive voice of movement, survivors of torture are welcomed home.

The complex relational dynamic that is present in the act of torture creates a need for a modality as powerful as DMT to be carefully paced, or titrated. It is often necessary to build a survivor’s resources before he/she can actually move through the experience. Children are especially vulnerable to suffering permanent fragmentation and relational scars after being tortured. Internalizing the experience of torture impacts their developmental process, and the resultant sequelae require that the therapeutic process be a careful negotiation of boundaries and of internal and external experience.

The survivor described in this paper benefited from his work with DMT. Recent correspondence from Haiti indicated that George continues to make progress, uses his legs more, and actually allowed himself to be photographed with a large group of children. This was another first for him.

There are several recommendations that arise from this case material. The first is the importance of an integrated treatment for survivors of torture who have already suffered tremendous fragmentation. This requires flexibility in our roles as caregivers, and may require that one person fill several roles to integrate the healing process. It may also require extensive teamwork. A second is the recognition that a goal of this work will almost always be the reconstruction of relationship. For many survivors, the therapeutic relationship is the one that initiates the healing process, but the work must continue with members of the

survivor's family, community or environment. It is often advisable for survivors to enter group therapy to begin this larger relational healing.

Child survivors present an additional challenge, and relational and/or group work is particularly appropriate for them. Their vulnerability and malleability make them susceptible to long-term suffering and permanent psychological scarring if they are not given adequate, compassionate treatment and an opportunity to reconstruct their experience of the world. Finally, the survivor's relationship with his/her own body suffers following torture, because a familiar place has become disconnected, unfamiliar and even unfriendly. All rehabilitative work with survivors of torture must take this into account. Recognition that the body is an earthly and sacred site for individual and collective human experience facilitates the reintegration and reclamation of body, mind, heart, and spirit.

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SHARE YOUR EXPERIENCES AND THOUGHTS WITH YOUR COLLEAGUES!

CALL FOR SUBMISSIONS

How to Contribute to Dialogus

Dialogus encourages submissions from those who work with survivors of torture.

We welcome your contributions of:

Issues related to treating survivors of torture: articles or informal pieces on various innovative clinical interventions and programs, how you handled challenging cases or situations, policies, and other information relevant to work with survivors.

Informal interactive articles that explore observations and challenges, and pose questions to the other members of this e-newsletter forum

History of your program

Descriptions of research or assessment instruments that are currently being used with torture survivors, or are being developed and tested

Descriptions of research studies and projects

Book and article reviews

Resource information on: conferences; training opportunities; call for papers; grants; new books, manuscripts, or monographs; interventions and programs; where to order useful clinical supplies or training materials; and other resources

Informative Internet sites and resources

News

Submission Guidelines:

1. All article submissions should be between 500 to 900 words, not including references. Shorter submissions are also encouraged.
2. Author(s) of article submissions should include a 50-word or shorter biographical sketch of author(s), and include an e-mail address where the readers can contact the author(s).
3. The editors of Dialogus would prefer if you would send the attachment of your article or other submissions in Microsoft Word 7.0 or in Rich Text Format.
4. Submissions should be sent to the editors of Dialogus at: PTVNewsletter@usa.com.

We anticipate publishing this e-newsletter on a bimonthly basis. For more information, please e-mail PTVNewsletter@usa.com.

RESOURCES

Web Sites of Torture Treatment Centers in the U.S.:

Below is a partial list of Web site addresses of some of the torture treatment centers in the U.S. We do not have the Web site addresses for all of the centers in the U.S. Please let us know if we are missing some Web sites or if we do not have the correct addresses, so that we can circulate an updated list.

Location of Program
Program Name & Web address
California
Los Angeles, CA

San Diego, CA

San Francisco, CA

San Jose, CA

Program for Torture Victims

www.ProgramForTortureVictims.org

Survivors of Torture, International (SOTI)
www.notorture.org

Survivors International
www.survivorsintl.org

The Center for Survivors of Torture

www.aaci.org

Colorado
Denver, CO

Rocky Mountain Survivors Center
www.home.earthlink.net/~rmsc

Massachusetts
Boston, MA

Boston Center for Refugee Health and Human Rights

www.glphr.org/BCRHHR_index.html

International Survivors Center
www.iiboston.org/isc.htm

Minnesota
Minneapolis, MN

Center for Victims of Torture
www.cvt.org

New York

New York, NY

Human Rights Clinic – Doctors of the World
www.doctorsoftheworld.org

Oregon

Eugene, OR

Amigos de los Sobrevivientes
www.pacinfo.com/eugene/tsnet

This e-newsletter is sponsored by the Program for Torture Victims (PTV), which has been providing medical and psychological services to torture survivors in the Greater Los Angeles area since 1980.

* Dialogus encourages you to forward this e-newsletter and share any information with colleagues. However, the authors who contribute to Dialogus would appreciate your contacting them for
permission to use the information in any articles or manuscripts and using proper citations. *

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